ALL ISLAND NEUROLOGY

Anila Siddiqui MD

Board Certified Neurologist
Board Certified Sleep Specialist
Clinical Neurophysiologist

PATIENT REGISTRATION FORM

PATIENT INFO

FIRST/MIDDLE/LAST NAME			
HOME ADDRESS			
EMAIL ADDRESS			
HOME PHONE #		WORK PHONE #	MOBILE PHONE #
LANGUAGE	DOB	SOCIAL SECURITY #	MARITAL STATUS
PRIMARY CARE PHYSICIAN		EMPLOYER	
EMERGENCY CONTACT		EMERGENCY PHONE #	
PHARMACY NAME		PHARMACY ADDRESS & PHONE#	

RESPONSIBLE

PERSON RESPONSIBLE FOR PAYMENT IF PATIENT IS UNDER AGE 18		
FIRST/MIDDLE/LAST NAME		
STREET ADDRESS		
HOME PHONE #	DOB	SOCIAL SECURITY #
EMPLOYER NAME	EMPLOYER PHONE #	

INSURANCE INFO

PRIMARY INSURANCE		
PRIMARY INSURANCE NAME	PRIMARY INSURANCE ADDRESS	
SUBSCRIBER NAME	DOB	SEX
SUBSCRIBER ID #	GROUP #	RELATION TO PATIENT
SECONDARY INSURANCE		
SECONDARY INSURANCE NAME	SECONDARY INSURANCE ADDRESS	
SUBSCRIBER NAME	DOB	SUBSCRIBER NAME
SUBSCRIBER ID #	GROUP #	SUBSCRIBER ID #

RELEASE

I understand and accept that I will be financially responsible for all deductibles, co-payments, co-insurances, and non-covered charges as provided by my insurance plan. If I fail to cancel my appointment without at least 24 hours prior notice, a fee will be charged. If my insurance *plan* requires a valid referral to receive medical care, I understand that it is my responsibility to provide such referral. If my referral is determined to be invalid by my insurance carrier, I understand that I will be financially responsible for balances on my account including non-covered items. If my insurance plan is not accepted by this office or is of the indemnity type, I understand that I am financially responsible for all balances remaining after payment, if any, made by my insurance plan. I hereby authorize and assign directly to Maple Medical, LLP, all medical benefits, if any, otherwise payable to me for services rendered. I hereby authorize the physician and/or their representative(s) to release any and all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Patient Signature: ______________________ Date: ______________

910 Route 109 Suite B Lower Level, Lindenhurst NY 11757
380 Merrick Avenue, East Meadow NY 11554

Phone: 516-279-6210 Fax: 516-596-8979

Personal Medication List

Date: ________________

Name ____

Height___________________________ Weight ___________________________________

Drug Allergies ____

Local Pharmacy and Phone____

Primary Doctor Name ____

Primary Doctor Address/ Phone ____

Patient Phone ____

Medication	Dose	Frequency	Purpose or Reason Taken	Form (Liquid, Capsule, tablet)

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Patient Name: ______________________ Date of Birth: ______________

Why are we asking these questions? In 2009 Congress passed the HITECH Act to create uniformity among electronic health records. Asking for your language ensures that you and your healthcare providers will be able to communicate clearly. We will be asking about race & ethnicity because some groups are at a higher risk of developing certain diseases. This information will be updated in your medical records and will remain confidential.

Preferred Language: ◊ English ◊ Spanish ◊ Chinese ◊ Italia ◊French

◊German ◊ Japanese ◊Korean ◊ Other _______________

◊ Decline to answer

Race: ◊ African American ◊ American Indian ◊ Asian

◊ Caucasian/White ◊ Native Hawaiian or Pacific Island

◊ Unknown ◊ Other ____________________

◊ Decline to answer

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HIPAA (Health Insurance Portability and Accountability Act) PROVIDES PATIENTS WITH REASSURANCE THAT THEIR INFORMATION IS PRIVATE. WE GIVE YOU THE RIGHT TO PUT RESTICTIONS ON YOUR PERSONAL INFORMATION. PLEASE ANSWER THE FOLLOWING QUESTIONS TO ALLOW US TO PROVIDE YOU WITH THE MEDICAL CONFIDENTIALITY YOU WANT AND DESERVE.

- I WISH TO BE CONTACTED IN THE FOLLOWING MANNER REGARDING APPOINTMENT CONFIRMATIONS, INSURANCE PROBLEMS AND/OR TEST RESULTS: (PLEASE CHECK ALL THAT APPLY)

  ☐ HOME PHONE ☐ CELL PHONE ☐ WORK PHONE

- IN REGARDS TO THE QUESTION ABOVE, MAY WE LEAVE A MESSAGE WITH THE ABOVE INFORMATION, EITHER MACHINE OR WITH A PERSON, EVEN IF THE MESSAGE MAY INCLUDE A DIAGNOSIS OR OTHER MEDICAL INFORMATION?

  ☐ YES, A MESSAGE IS FINE ☐ NO, PLEASE DO NOT LEAVE MESSAGES
  ☐ YES, BUT PLEASE DO NOT LEAVE A DIAGNOSIS

PLEASE LIST BELOW ANY FAMILY MEMBERS OR FRIENDS WHO YOU ALLOW TO HAVE CERTAIN ACCESS TO YOUR PROTECTED HEALTH INFORMATION.
(I.E. CALLING OUR OFFICE TO MAKE AND/OR CONFIRM AN APPOINTMENT FOR YOU, CALLING FOR RESULTS, PICKING UP A PERSCRIPTION)

☐NAME____________________ RELATION____________

☐NAME____________________ RELATION____________

☐NAME____________________ RELATION____________

☐ I WOULD PREFER NO OUTSIDE ACCESS

PATIENT NAME______________________

SIGNATURE ______________________ DATE__________

WITNESS______________________ DATE__________

NOTICE OF HIPAA PRIVACY POLICY

ACKNOWLEDGMENT OF RECEIPT

☐ PATIENT SIGNATURE______________________________
(ACCEPT HIPAA PRIVACY)

☐ PATIENT SIGNATURE______________________________
(DECLINE HIPAA PRIVACY)

PRINT NAME____________________ DATE__________